VERMONT

Office of Vermont Health Access *Agency of Human Services*
312 Hurricane Lane Suite 201
Williston, VT 05495-2086
www.ovha.state.vt.us

This letter is important. If you do not understand it, take it to your local office for help.
Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.
Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.
Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.
Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.
Laù thö naøy raát quan troïng. Neáu quyù vò khoâng hieåu noäi dung trong ñoù, haøy ñem thö naøy ñeán vaên phoøng taïi ñòa phöông cuûa quyù vò ñeå ñöôïc giuùp ñôõ.

What You Can Do if You are Unhappy About Your Health Care Coverage

Starting July 1, 2007, OVHA and other state departments that provide services have a new way for you to ask us to review our decisions about the services you may get through your state health plan. These new options apply to people on Medicaid, Dr. Dynasaur, the Vermont Health Access Plan (VHAP), VPharm, VHAP-Pharmacy, or VScript.

If you don't agree with our decision to deny, limit, reduce or stop a service, you may ask us to review that decision. You may also ask for a review if we don't act when we said we would. If OVHA made the decision, contact Member Services to ask for your **reconsideration, appeal, or fair hearing** (described below) by calling 1-800-250-8427 (TTY 1-888-834-7898) or writing to:

Health Access Member Services
Office of Vermont Health Access
101 Cherry Street, Suite 320
Burlington, VT 05401

If another department made the decision, contact that department. There will be contact information on the decision letter.

Reconsideration

This may help you solve your problem quickly, with a less formal process like an appeal or fair hearing (see below). You or your provider may ask the department that made the decision to reconsider it. You or your provider may give us more information or clarify what you have already provided. The person who made the decision will review your case and look at any new information, which may result in a new decision. However, reconsideration is optional. You can choose to go directly to an appeal or fair hearing.

Appeal

An appeal is heard by a qualified person who was not involved in the original decision. You and your provider will be invited to a meeting with this person to explain your viewpoint. If you have someone who represents you, they may come to this meeting as well. This meeting can also take place on the phone.

At the meeting, you will be able to present your case for why you think the decision is wrong. You have 90 days from the date the decision was mailed to ask for an appeal. Your provider may ask for the appeal if you wish. We will try to decide your appeal in 30 days; however, it can take up to 45 days. You and the state also have the option to request up to 14 more days but only if it might help you. For example, your provider may need more time to send important information or more time might be needed to set up a meeting time that is good for you or other people who will take part. The longest it will ever take for a decision to be made is 59 days.

If you think your need for the denied benefit is urgent because your health will be seriously harmed, you may ask for an **expedited appeal**. If it is decided that your appeal is urgent, you will get a decision within three working days.

If your benefit changed because of a change in a federal or state law, you may not ask for an appeal but may ask for a fair hearing.

Fair Hearing

If you disagree with our original decision or the appeal decision, you may ask the department that made the decision for a fair hearing. You have 90 days from the date the original notice of decision or action was mailed to ask for a fair hearing, or 30 days from the date of an appeal decision notice. A fair hearing is a legal proceeding in which an impartial hearing officer will review the decision. You may bring a friend, relative, or other representative who can help you present your case. Your provider may also participate.

Your Choice

You may choose to ask for both an appeal and a fair hearing at the same time, just an appeal, or just a fair hearing.

You may also call the Office of Health Care Ombudsman at 1-800-917-7787 for help with any part of this process or for help in deciding what to do.

Grievances

A **Grievance** is a complaint about things like the location of your health care provider, the manner in which you were treated, or the quality of the health care provided. If you can't work out your differences with your provider and it is within 60 days of when the problem took place, you may file a grievance by contacting Member Services. Filing a grievance means that you explain your complaint and say that you want a written response from OVHA. Within 90 days, we will send you a letter about how we can address it.

If your grievance is related to another department, contact that department to file your grievance. If you are not sure who to contact, call Member Services or the Office of Health Care Ombudsman.

If you filed a grievance and are not happy with the way it was addressed, you may ask for a **Grievance Review**. An impartial person will review your grievance to be sure that the grievance process was handled fairly. You will get a letter with the results of the review.